FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031765

Facility Name: Briar Place

Address: 6800 West Joliet Road (Number) Indian Head Park (City) 60525 (Zip Code)

County: Cook

Telephone Number: (708) 246-8500 **Fax #** (708) 246-0086

HFS ID Number: 363472799001

Date of Initial License for Current Owners: 11/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3	144	Intermediate (ICF)	144	52,560	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	232	TOTALS	232	84,680	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	25,404	1,395	4,829	31,628	8
9	SNF/PED					9
10	ICF	41,567	2,283	2,428	46,278	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,971	3,678	7,257	77,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.00%

D. How many bed-hold days during this year were paid by the Department? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 84 and days of care provided 4,139

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	344,519	39,802	21,208	405,529		405,529	(5,131)	400,398			1
2	Food Purchase		315,185		315,185		315,185	2,882	318,067			2
3	Housekeeping	170,042	46,340		216,382		216,382	(3,983)	212,399			3
4	Laundry	138,560	39,212		177,772		177,772		177,772			4
5	Heat and Other Utilities			236,858	236,858		236,858	3,080	239,938			5
6	Maintenance	247,337		148,375	395,712		395,712	8,386	404,098			6
7	Other (specify):*							2,836	2,836			7
8	**TOTAL General Services**	900,458	440,539	406,441	1,747,438		1,747,438	8,071	1,755,509			8
	B. Health Care and Programs											
9	Medical Director			14,155	14,155		14,155		14,155			9
10	Nursing and Medical Records	2,206,820	160,328	75,856	2,443,004		2,443,004	(99,890)	2,343,114			10
10a	Therapy	93,589		817	94,406		94,406	736	95,142			10a
11	Activities	124,744	7,428	2,352	134,524		134,524		134,524			11
12	Social Services	314,324			314,324		314,324		314,324			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							1,745	1,745			15
16	**TOTAL Health Care and Programs**	2,739,477	167,756	93,180	3,000,413		3,000,413	(97,409)	2,903,004			16
	C. General Administration											
17	Administrative	115,413			115,413		115,413	45,965	161,378			17
18	Directors Fees											18
19	Professional Services			386,166	386,166	(4,000)	382,166	(299,281)	82,885			19
20	Dues, Fees, Subscriptions & Promotions			110,156	110,156		110,156	(28,074)	82,082			20
21	Clerical & General Office Expenses	82,574	25,524	260,684	368,782		368,782	50,870	419,652			21
22	Employee Benefits & Payroll Taxes			630,550	630,550		630,550	(7,944)	622,606			22
23	Inservice Training & Education			488	488		488		488			23
24	Travel and Seminar			1,726	1,726		1,726	6,563	8,289			24
25	Other Admin. Staff Transportation			31,483	31,483		31,483	(15,000)	16,483			25
26	Insurance-Prop.Liab.Malpractice			233,403	233,403		233,403	2,419	235,822			26
27	Other (specify):*							44,216	44,216			27
28	**TOTAL General Administration**	197,987	25,524	1,654,656	1,878,167	(4,000)	1,874,167	(200,266)	1,673,901			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,837,922	633,819	2,154,277	6,626,018	(4,000)	6,622,018	(289,604)	6,332,414			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Briar Place #0031765 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			139,619	139,619		139,619	217,571	357,190			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			473	473		473	541,260	541,733			32
33	Real Estate Taxes			295,274	295,274	4,000	299,274	2,532	301,806			33
34	Rent-Facility & Grounds			942,530	942,530		942,530	(930,537)	11,993			34
35	Rent-Equipment & Vehicles			9,837	9,837		9,837	2,173	12,010			35
36	Other (specify):*			4,234	4,234		4,234		4,234			36
37	**TOTAL Ownership**			1,391,967	1,391,967	4,000	1,395,967	(167,001)	1,228,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		194,886	211,818	406,704		406,704	(7,459)	399,245			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,020	127,020		127,020		127,020			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		194,886	338,838	533,724		533,724	(7,459)	526,265			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,837,922	828,705	3,885,082	8,551,709		8,551,709	(464,064)	8,087,645			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	20,446	30		9
10	Interest and Other Investment Income	(274,913)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(149)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,566)	21		18
19	Entertainment				19
20	Contributions	(1,054)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(172,616)	21		24
25	Fund Raising, Advertising and Promotional	(33,644)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(118,305)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (599,301)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	135,237		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 135,237		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (464,064)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Briar Place

ID# 0031765

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (107)	21	1
2	Other Income - Pharmacy	(2,826)	39	2
3	Jury Duty	(69)	10	3
4	Collection Expense	(5,127)	21	4
5	Ancillary-Pharmacy Veterans	(93,927)	10	5
6	Ancillary-Radiology Veterans	(558)	10	6
7	Non-Allowable Billing Consulting	(8,571)	19	7
8	Prior Year Legal	(2,005)	19	8
9	Capitalized R & M	(5,923)	06	9
10				10
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99				99
100				100
101	**Total**	(118,305)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				5	489		(2,886)	(2,739)				(5,131)	1
2	Food Purchase	(149)							3,031				2,882	2
3	Housekeeping				(3,983)								(3,983)	3
4	Laundry													4
5	Heat and Other Utilities					3,080							3,080	5
6	Maintenance	(5,923)			(31)	7,527		6,789	24				8,386	6
7	Other (specify):*						702	1,777	357				2,836	7
8	**TOTAL General Services**	(6,072)			(4,009)	11,096	702	5,680	673				8,071	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(94,546)			(5,344)								(99,890)	10
10a	Therapy							736					736	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						1,644	101					1,745	15
16	**TOTAL Health Care and Programs**	(94,546)			(5,344)		1,644	837					(97,409)	16
	C. General Administration													
17	Administrative					5,047		40,745	173				45,965	17
18	Directors Fees													18
19	Professional Services	(10,576)				(288,709)			4				(299,281)	19
20	Fees, Subscriptions & Promotions	(34,698)				6,619			5				(28,074)	20
21	Clerical & General Office Expenses	(196,916)				24,603		222,787	396				50,870	21
22	Employee Benefits & Payroll Taxes				(422)		(7,522)						(7,944)	22
23	Inservice Training & Education													23
24	Travel and Seminar					6,426			137				6,563	24
25	Other Admin. Staff Transportation					(15,000)							(15,000)	25
26	Insurance-Prop.Liab.Malpractice					2,296			123				2,419	26
27	Other (specify):*						6,406	37,810					44,216	27
28	**TOTAL General Administration**	(242,190)			(422)	(258,718)	(1,116)	301,342	838				(200,266)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(342,808)			(9,774)	(247,622)	1,230	307,859	1,511				(289,604)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Briar Place** **#** **0031765** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	20,446	164,469			32,081			66	509			217,571	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(274,913)	810,416			5,356			221	180			541,260	32
33	Real Estate Taxes					2,532							2,532	33
34	Rent-Facility & Grounds		(942,530)			11,993							(930,537)	34
35	Rent-Equipment & Vehicles					2,161			12				2,173	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(254,467)	32,355			54,123			299	689			(167,001)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(2,026)			(195)				(3,708)	(1,530)			(7,459)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(2,026)			(195)				(3,708)	(1,530)			(7,459)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(599,301)	32,355		(9,969)	(193,499)	1,230	307,859	(1,898)	(841)			(464,064)	45

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached	See Attached			
			GWH Limited Partnership			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 942,530	GWH Limited Partnership	100.00%	$	$ (942,530)	1
2	V	30	Depreciation Expense				164,469	164,469	2
3	V	32	Interest				810,416	810,416	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 942,530			$ 974,885	$ * 32,355	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 85,689	$ 85,689	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	85,689	CCS EMPLOYEE BENEFIT GROUP	100.00%		(85,689)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 85,689			$ 85,689	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ (53)	XCEL MEDICAL SUPPLY, LLC	100.00%	$ (48)	$ 5	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	40,178	XCEL MEDICAL SUPPLY, LLC	100.00%	36,195	(3,983)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	309	XCEL MEDICAL SUPPLY, LLC	100.00%	278	(31)	19
20	V	10	NURSING	53,900	XCEL MEDICAL SUPPLY, LLC	100.00%	48,557	(5,344)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	4,252	XCEL MEDICAL SUPPLY, LLC	100.00%	3,830	(422)	24
25	V	39	ANCILLARY	1,972	XCEL MEDICAL SUPPLY, LLC	100.00%	1,776	(195)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,558			$ 90,588	$ * (9,969)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 489	$ 489	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	3,080	3,080	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	7,527	7,527	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	5,047	5,047	19
20	V	19	Professional Fees	316,970	Care Centers, Inc.	100.00%	28,261	(288,709)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	6,619	6,619	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	24,603	24,603	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	6,426	6,426	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	2,296	2,296	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	32,081	32,081	25
26	V	32	Interest		Care Centers, Inc.	100.00%	5,356	5,356	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,532	2,532	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	11,993	11,993	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,161	2,161	29
30	V	25	Bus Reimbursement	15,000	Care Centers, Inc.	100.00%		(15,000)	30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 331,970			$ 138,471	$ * (193,499)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 4,879	Care Centers, Inc.	100.00%	$ 4,879	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	702	702	16
17	V	10	Nursing Salary	10,797	Care Centers, Inc.	100.00%	10,797		17
18	V	10a	Rehab Salary	553	Care Centers, Inc.	100.00%	553		18
19	V								19
20	V								20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,644	1,644	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	33,638	Care Centers, Inc.	100.00%	33,638		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	6,406	6,406	24
25	V	22	Employee Benefits	7,522	Care Centers, Inc.	100.00%		(7,522)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 57,389			$ 58,619	$ * 1,230	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 8,468	Care Centers, Inc.	100.00%	$ 5,582	$ (2,886)	15
16	V								16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	6,789	6,789	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,777	1,777	18
19	V								19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	736	736	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	101	101	21
22	V								22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	40,745	40,745	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	222,787	222,787	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	37,810	37,810	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,468			$ 316,327	$ * 307,859	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 5,762	Care Centers, Inc. - Health Systems Division	100.00%	$ 673	$ (5,089)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	3,031	3,031	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	24	24	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	173	173	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	4	4	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	396	396	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	137	137	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	123	123	23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	66	66	24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	221	221	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	12	12	26
27	V	39	Ancillary Enteral Supplies	7,825	Care Centers, Inc. - Health Systems Division	100.00%	4,117	(3,708)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,350	2,350	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	357	357	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 13,587			$ 11,689	$ * (1,898)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 509	$ 509	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	180	180	16
17	V	39	Vent Reimbursement	1,530	Vent Lease, LLC.	100.00%		(1,530)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,530			$ 689	$ * (841)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	31.43%	See Attached	1.65	3.57%	CCI Salary	$ 3,975	17-7	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.57	1.43%	CCS - VEBA	698	22-7	2
3	Mark Steinberg	Owner	Administrative	2.04%	See Attached	2.86	5.20%	CCI Salary	3,828	17-7	3
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.69	1.97%	CCS-VEBA,CCI	1,225	22-7	4
5	Gale Rothner	Relative	Administrative	0.00%	See Attached	1.82	5.20%	CCI Salary	4,058	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,784		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 85,689	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 85,689	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ (48)	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						36,195	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						278	5
6	10	NURSING	Direct Allocation						48,557	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						3,830	10
11	39	ANCILLARY	Direct Allocation						1,776	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 90,588	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	77,906	$ 489	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		77,906	3,080	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		77,906	7,527	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		77,906	5,047	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		77,906	28,261	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		77,906	6,619	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		77,906	24,603	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		77,906	6,426	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		77,906	2,296	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		77,906	32,081	11
12	32	Interest	Patient Days	1,497,287	32	102,930		77,906	5,356	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		77,906	2,532	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		77,906	11,993	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		77,906	2,161	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 138,471	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		4,879	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			702	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		10,797	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464		553	4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			1,644	7
8	17	Administration Salary	Direct Cost			5,566	5,566			8
9	21	Office Salary	Direct Cost			419,879	419,879		33,638	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906			6,406	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 58,619	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	77,906	$ 5,582	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	77,906	6,789	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		77,906	1,777	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	77,906	736	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		77,906	101	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	77,906	40,745	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	77,906	222,787	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		77,906	37,810	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 316,327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		13,587	673	1
2	02	Food	Income			160,931			3,031	2
3	06	Maintenance	Billable Income	928,452		1,614		13,587	24	3
4	17	Administration	Billable Income	928,452		11,797		13,587	173	4
5	19	Professional Fees	Billable Income	928,452		262		13,587	4	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		13,587	5	6
7	21	Office & Clerical	Billable Income	928,452		27,087		13,587	396	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		13,587	137	8
9	26	Insurance	Billable Income	928,452		8,379		13,587	123	9
10	30	Depreciaton	Billable Income	928,452		4,499		13,587	66	10
11	32	Interest	Billable Income	928,452		15,077		13,587	221	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		13,587	12	12
13	39	Ancillary Enteral Supplies	Income			327,517			4,117	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	13,587	2,350	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		13,587	357	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 11,689	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	1,530	$ 509	1
2	32	Interest	Direct Billing	593,410	29	69,863		1,530	180	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 689	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Premier Bank		X	Auto Loan	$355.61	4/4/03	$ 11,583	$ 1,403	4/06	6.5000	$ 473	1
2	White Oak Nursing Center		X	Mortgage	$78,544.00	3/1/97	7,441,383	6,680,247	11/01/21	12.0000	810,376	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	5/3 Bank		X	Working Capital							40	6
7	Care Centers Allocation		X								5,577	7
8	See Supplemental Schedule										180	8
9	TOTAL Facility Related				$78,899.61		$ 7,452,966	$ 6,681,650			$ 816,646	9
	B. Non-Facility Related*											
10	Interest Income		X								(274,913)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (274,913)	14
15	TOTALS (line 9+line14)						$ 7,452,966	$ 6,681,650			$ 541,733	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Vent Lease		X				$	$			$ 180	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										180	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 293,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 289,807	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,793)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 301,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 4,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 301,807	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	247,528	8
	2001	261,097	9
	2002	288,228	10
	2003	279,622	11
	2004	287,275	12

2004 Accrual = $287,275 x 1.05 = $301,600

Allocated from Care Centers $2,531.98

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-20-102-035	Long term Care Facility	$ 287,274.51	$ 287,274.51
2.	Care Centers Allocation	home Office Allocation	$ 113,485.70	$ 2,531.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 400,760.21	$ 289,806.49

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

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2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Briar Place COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031765

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,200 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1997	$ 402,069	1
2	2201 West Main Allocation			18,299	2
3	TOTALS			$ 420,368	3

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	5,000		20	219	219	4,987	9
10	Various			1987	138,915		20	7,310	7,310	136,461	10
11	Various			1988	9,885		20	519	519	9,201	11
12	Various			1989	5,410		20	264	264	4,312	12
13	Various			1990	42,578		20	2,130	2,130	33,132	13
14	Various			1991	11,813		20	591	591	8,767	14
15	Various			1992	11,426		20	571	571	7,614	15
16	Various			1993	8,851		20	443	443	7,279	16
17	Various			1994	25,632		20	1,282	1,282	14,442	17
18	Various			1995	50,028		20	2,502	2,502	26,385	18
19	Various			1996	161,111		20	8,053	8,053	71,816	19
20	Various			1997	165,320		20	8,266	8,266	72,962	20
21	Various			1998	185,999		20	9,301	9,301	70,763	21
22	Various			1999	23,879		20	1,177	1,177	7,647	22
23	Various			2000	122,845		20	6,171	6,171	33,297	23
24	Various			2001	51,096		20	2,554	2,554	11,725	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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45									45
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,041,541	164,469		183,266	18,797	1,464,760	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		71,818	2,943		2,943		8,870	68
69	Financial Statement Depreciation			139,619			(139,619)		69
70	TOTAL (lines 4 thru 69)		$ 8,133,147	$ 307,031		$ 237,562	$ (69,469)	$ 1,994,420	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,133,147	$ 307,031		$ 237,562	$ (69,469)	$ 1,994,420	1
2	Transformer	2002	644		20	92	92	368	2
3	Cooler Door	2002	1,850		20	123	123	411	3
4	P A Amplifier	2002	690		20	99	99	320	4
5	Walk In Freezer Repair	2002	607		20	87	87	275	5
6	Sprinkler System	2002	2,000		20	200	200	800	6
7	Paint	2002	678		20			678	7
8	Tuckpointing	2002	5,100		20	510	510	2,040	8
9	Door Closers	2002	3,270		20	327	327	1,308	9
10	Smoke Damper	2002	3,520		20	293	293	1,173	10
11	Program Alarm	2002	874		20	125	125	499	11
12	Fire Safety Eval	2002	2,919		20	417	417	1,633	12
13	Roof Maintenance	2002	3,650		20	365	365	1,430	13
14	Flooring	2002	2,874		20	192	192	750	14
15	Plumbing Repair	2002	766		20	77	77	294	15
16	Plumbing Repair	2002	613		20	61	61	230	16
17	Rod Out Sewer	2002	860		20	86	86	315	17
18	Plumbing	2002	603		20	60	60	206	18
19	Paint	2002	557		20			557	19
20	Plumbing	2002	603		20	60	60	196	20
21	Windows	2002	36,000		20	3,600	3,600	11,700	21
22	Paint	2002	828		20			828	22
23	Digital Card-Phone	2003	573		20	57	57	172	23
24	Duct-Gener Rm	2003	1,480		20	74	74	222	24
25	Plumbing Work	2003	5,470		20	274	274	821	25
26	Panic Devices	2003	1,402		20	140	140	421	26
27	Hospital Latch	2003	1,856		20	186	186	557	27
28	Refractory Replace.	2003	3,228		20	323	323	968	28
29	Ignition Module	2003	570		20	29	29	86	29
30	Repair Frozen Coils	2003	1,660		20	83	83	249	30
31	Repair Leak Turbo Charger	2003	1,450		20	73	73	218	31
32	Rep. Walk In Freezer	2003	524		20	26	26	79	32
33	New Windows	2003	66,234		20	6,623	6,623	19,318	33
34	TOTAL (lines 1 thru 33)		$ 8,287,100	$ 307,031		$ 252,224	$ (54,807)	$ 2,043,542	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,287,100	$ 307,031		$ 252,224	$ (54,807)	$ 2,043,542	1
2	Paint	2003	1,015		20	101	101	296	2
3	Part For Boiler	2003	697		20	35	35	102	3
4	Plumbing Repair	2003	1,010		20	101	101	295	4
5	Coils	2003	4,900		20	327	327	926	5
6	Testing Of Coils For Leaks	2003	720		20	48	48	136	6
7	Generator	2003	1,449		20	72	72	205	7
8	Generator	2003	1,960		20	98	98	278	8
9	Paint Job	2003	931		20	93	93	256	9
10	Replaced Refractory Tiles	2003	3,228		20	161	161	444	10
11	Boiler	2003	1,290		20	64	64	177	11
12	A/C Parts	2003	586		20	29	29	76	12
13	Void	2003	(925)		20	(92)	(92)	(239)	13
14	Plumbing Equipment	2003	658		20	66	66	165	14
15	Fresh Air Dampers	2003	3,000		20	150	150	375	15
16	A/C Repair	2003	1,486		20	74	74	180	16
17	Generator	2003	1,132		20	57	57	137	17
18	Tar Coating On Parking Lot	2003	2,471		20	247	247	597	18
19	Paint	2003	685		20	69	69	160	19
20	Fence Repair	2003	550		20	55	55	128	20
21	4 New Doors	2003	3,650		20	365	365	852	21
22	Repair Of Air Handling Unit	2003	1,342		20	67	67	151	22
23	Installed Detector & Door Screen	2003	1,526		20	76	76	172	23
24	Water Heater Repair	2003	585		20	29	29	66	24
25	Generator Maintenance	2004	1,223		20	245	245	449	25
26	Labor & Equip. For Plumbing	2004	735		20	147	147	245	26
27	Retiling Of Shower Stalls	2004	5,000		20	500	500	792	27
28	Installation Of Sprinkler Heads	2004	9,300		20	930	930	1,473	28
29	Parts For Doors	2004	1,925		20	192	192	257	29
30	Repair On Sewage Pump	2004	1,243		20	249	249	331	30
31	Dp On New 2Nd Floor Showers	2004	4,000		20	400	400	467	31
32	Generator Repair	2004	620		20	124	124	145	32
33	Sprinkler System Repair	2004	2,295		20	459	459	535	33
34	TOTAL (lines 1 thru 33)		$ 8,347,387	$ 307,031		$ 257,762	$ (49,269)	$ 2,054,171	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,347,387	$ 307,031		$ 257,762	$ (49,269)	$ 2,054,171	1
2	Glass Frames & Door Hinges	2004	748		20	150	150	162	2
3	Glass Frames & Door Hinges	2004	518		20	104	104	112	3
4	Fire Dampers	2004	581		20	83	83	90	4
5	Installation Of Window	2004	1,275		20	255	255	276	5
6	Painting	2004	774		20	39	39	77	6
7	Gas Valve Repair	2004	733		20	37	37	67	7
8	Painting	2004	1,065		20	53	53	98	8
9	Plaster & Paint Rooms	2004	7,000		20	350	350	496	9
10	Asphalt Patching	2004	1,200		20	60	60	85	10
11	Walk-In Cooler Repair	2004	870		20	44	44	58	11
12	Air Filters	2004	758		20	38	38	44	12
13	Remodeling Of 2Nd Floor	2005	9,050		20	830	830	830	13
14	Installation Of New Grease Trap For Kitchen	2005	10,710		20	893	893	893	14
15	New Water Pump For Air Conditioner	2005	5,142		20	686	686	686	15
16	New Patio Awning	2005	7,900		20	395	395	395	16
17	Generator Repairs	2005	3,520		20	352	352	352	17
18	Repalced Compressor On A/C Chiller	2005	5,496		20	458	458	458	18
19	Installed Norstar Mics Phone System	2005	15,250		20	1,017	1,017	1,017	19
20	Furnish And Install Door Protection	2005	1,725		20	86	86	86	20
21	Replace Sprinkler Heads	2005	2,105		20	105	105	105	21
22	Camera Instlation	2005	2,093		20	209	209	209	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
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10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,425,900	$ 307,031		$ 264,007	$ (43,024)	$ 2,060,767	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	232		1997	1976	$ 7,041,541	$ 164,469		$ 183,266	$ 18,797	$ 1,464,760	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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14											14
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30											30
31											31
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,041,541	$ 164,469		$ 183,266	$ 18,797	$ 1,464,760	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated from 2201 West Main		2002	2002	$ 25,217	$ 647	35	$ 647	$	$ 2,128	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from 2201 West Main			2002	20,832	1,042	20	1,042		3,646	9
10	Allocated from 2201 West Main			2003	24,549	1,227	20	1,227		3,069	10
11	Allocated from 2201 West Main			2005	1,220	27	20	27		27	11
12											12
13											13
14											14
15											15
16											16
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31											31
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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54									54
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57									57
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 71,818	$ 2,943		$ 2,943	$	$ 8,870	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 742,409	$ 26,630	$ 81,115	$ 54,485	10	$ 524,769	71
72	Current Year Purchases	45,383	509	3,056	2,547	10	3,056	72
73	Fully Depreciated Assets	199,371				10	199,371	73
74								74
75	TOTALS	$ 987,163	$ 27,139	$ 84,171	$ 57,032		$ 727,196	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		AUTOS - SEE ATTACHED		$ 82,963	$	$ 6,438	$ 6,438	5	$ 61,362	76
77		CC Allocation	1900	35,135	2,573	2,573		5	26,606	77
78										78
79										79
80	TOTALS			$ 118,098	$ 2,573	$ 9,011	$ 6,438		$ 87,968	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,951,529	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 336,743	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 357,189	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 20,446	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,875,931	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc. From Care Centers				11,993			5
6								6
7	TOTAL				$ 11,993 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,763 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Lincoln	$ 625.00	$ 7,246	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 7,246	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 103,633	$		$ 103,633	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			761			761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			107,424			107,424	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				156,849		156,849	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						38,037		38,037	13
14	TOTAL			$		$ 211,818	$ 194,886		$ 406,704	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,763	$ 2,763	1
2	Cash-Patient Deposits	59,080	59,080	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,844,927	2,146,527	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	242,442	242,442	6
7	Other Prepaid Expenses	2,962	2,962	7
8	Accounts Receivable (owners or related parties)	580,020	360,700	8
9	Other(specify): See Attached Schedule	4,030,007	4,030,007	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,762,201	$ 6,844,481	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		402,069	13
14	Buildings, at Historical Cost		6,414,314	14
15	Leasehold Improvements, at Historical Cost	1,147,487	1,147,487	15
16	Equipment, at Historical Cost	1,087,943	2,312,943	16
17	Accumulated Depreciation (book methods)	(1,729,555)	(4,400,520)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 505,875	$ 5,876,293	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,268,076	$ 12,720,774	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,611,017	$ 1,912,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,665	45,665	28
29	Short-Term Notes Payable	1,403	1,403	29
30	Accrued Salaries Payable	268,156	268,156	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,695	17,695	31
32	Accrued Real Estate Taxes(Sch.IX-B)	301,600	301,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,245,536	$ 2,547,136	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,680,247	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,680,247	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,245,536	$ 9,227,383	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,022,540	$ 3,493,391	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,268,076	$ 12,720,774	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,650,538	1
2	Restatements (describe):		2
3	See Attached	(61,027)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,589,511	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,433,029	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,433,029	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,022,540	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,564,745	1
2	Discounts and Allowances for all Levels	(1,094,821)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,469,924	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	910,735	6
7	Oxygen	10,163	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 920,898	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	244,643	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,536	19
20	Radiology and X-Ray	4,270	20
21	Other Medical Services	49,610	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 316,059	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	274,913	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 274,913	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,944	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,944	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,984,738	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,747,438	31
32	Health Care	3,000,413	32
33	General Administration	1,878,167	33
	B. Capital Expense		
34	Ownership	1,391,967	34
	C. Ancillary Expense		
35	Special Cost Centers	406,704	35
36	Provider Participation Fee	127,020	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,551,709	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,433,029	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,433,029	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Finished **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,144	2,608	$ 90,562	$ 34.72	1
2	Assistant Director of Nursing	988	1,377	41,549	30.17	2
3	Registered Nurses	17,220	18,123	497,441	27.45	3
4	Licensed Practical Nurses	27,219	29,313	731,332	24.95	4
5	CNAs & Orderlies	74,066	78,516	812,701	10.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,616	6,074	93,589	15.41	8
9	Activity Director	1,941	2,211	28,944	13.09	9
10	Activity Assistants	11,461	12,204	95,800	7.85	10
11	Social Service Workers	21,361	23,203	314,324	13.55	11
12	Dietician	1,934	2,103	30,024	14.28	12
13	Food Service Supervisor	1,941	2,163	40,599	18.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,192	30,966	273,896	8.85	15
16	Dishwashers					16
17	Maintenance Workers	18,936	20,416	247,337	12.11	17
18	Housekeepers	20,035	21,542	170,042	7.89	18
19	Laundry	14,605	15,793	138,560	8.77	19
20	Administrator	1,939	2,027	65,612	32.37	20
21	Assistant Administrator	1,707	1,707	49,801	29.17	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,257	6,784	82,574	12.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,981	2,154	33,235	15.43	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	259,543	279,284	$ 3,837,922 *	$ 13.74	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	261	$ 12,740	01-03	35
36	Medical Director	Monthly	14,155	09-03	36
37	Medical Records Consultant	9	378	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,349	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,352	11-03	44
45	Social Service Consultant				45
46	Other(specify) CCI - See Attached		19,818	various	46
47	Psychiatric Consultant	Monthly	1,500	10-03	47
48	Therapy Consultant	Monthly	264	10A-3	48
49	TOTAL (lines 35 - 48)	318	$ 54,556		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	289	$ 13,674	10-03	50
51	Licensed Practical Nurses	1,163	40,173	10-03	51
52	Certified Nurse Assistants/Aides	249	5,330	10-03	52
53	TOTAL (lines 50 - 52)	1,701	$ 59,177		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Boshes(1/1/05-8/21/05)	Administrator	0	$ 43,096
Hilda Derzsy(8/21/05-12/31/05)	Administrator	0	22,516
Hilda Derzsy(1/1/05-8/21/05)	Assist.Admin.	0	39,068
Rosemarie Obregon	Assist.Admin.	0	10,733
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,413

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting Fees	$ 18,152
Care Centers	Accounting Fees	15,000
Personnel Planners	Unemployment Consultant	5,050
Care Centers	Bookkeeping Services	47,328
Care Centers	Computer Services	8,352
ADP Payroll Services	Computer Services	11,670
IIT/Sourcetech LQP BP	Computer Services	715
E Health Data Solutions	MDS Software	1,770
Maxsource	Computer Services	620
Achieve Healthcare A/R Software	Computer Services	10,458
Care Centers	Home Office	194,880
		72,172
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 386,167

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,695
Unemployment Compensation Insurance	52,046
FICA Taxes	288,394
Employee Health Insurance	177,615
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	15,134
Holiday Expense	2,722
TOTAL (agree to Schedule V, line 22, col.8)	$ 622,606

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	48,959
Health Care Worker Background Check	4,117
(Indicate # of checks performed 179)	
ILCLTC	11,400
Dues and Subscribtions	911
Licenses & Fees	9,076
Alloc. From Care Centers	6,624
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,726
Alloc from Care Centers	6,563
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,289

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Briar Place # 0031765 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Briar Place # 0031765 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $11,400**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **157** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **127,020**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.